Dr. George Baehr, Medical Director of the Health Insurance Plan of Greater New York, Testifies Before the House Interstate and Foreign Commerce Committee

EXTENSION OF REMARKS
OF

HON. CHARLES A. WOLVERTON

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, January 14, 1954

Mr. WOLVERTON. Mr. Speaker, the testimony of Dr. George Baehr before the Committee on Interstate and Foreign Commerce at its hearing to develop a health program is very important. Dr. Baehr was chief of medical service and director of clinical research at Mt. Sinai Hospital in New York City. He was chairman of the technical advisory committee, Department of Health, New York City, 1933–41, and consultant, Department of Hospitals, New York City, 1933–45. He has been a member of the public health council of the State of New York since 1935 and is past president of the New York Academy of Medicine.

Dr. Baehr made the following statement on prepaid medical care plans and the health-insurance plan of Greater New York:

TESTIMONY PRESENTED BEFORE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE ON JANUARY 14, 1954, BY GEORGE BAEHER, M. D., PRESIDENT AND MEDICAL DIRECTOR, HEALTH INSURANCE PLAN OF GREATER NEW YORK

In all considerations of health insurance, the basic and interrelated issues are (1) the method of providing medical services to the insured, (2) the scope and quality of the services, and (3) the method of payment to physicians.

LIMITED COVERAGE BY MEDICAL EXPENSE INDEMNITY INSURANCE

Medical expense indemnity plans pay individual physicians on a fee-for-service basis. For this reason, they must limit the scope of their benefit coverage for the most part to diseases requiring admission to a hospital, the frequency of which is predictable within reasonable limits. Benefits outside of a hospital are generally excluded because the number of professional and laboratory services which physicians may choose to render outside of a hospital is unpredictable when physicians are paid a fee for each service by a third party. Even when some medical benefits outside of a hospital are included under medical expense indemnity contracts, they are sharply limited in amount and leave the insured families widely exposed to additional medical bills. Comprehensive benefit coverage is impossible under these indemnity, fee-for-service plans because it inevitably results in a rapid increase in medical bills and the progressive pyramiding of costs to the insurance company.

The inadequacy of in-hospital medical coverage as a means of protecting the family budget is revealed by the experience of such comprehensive programs of medical care as the health-insurance plan of Greater New York, which find that only 10.7 percent of all professional services are rendered to such insured persons in hospitals and 89 percent in their homes and doctor's offices. With fees for home and office visits and for X-rays, technical laboratory work, and other diagnostic and therapeutic procedures now rising to the point that care even for ambulatory patients may cost a week's wages, there is a growing need for prepayment that covers ambulatory as well as hospital care. Extra-hospital medical care is continually being needed by all families; hospital care is often not required for 20 or 30 years.

COMPREHENSIVE MEDICAL CARE THROUGH PREPAID GROUP PRACTICE

During the past 25 years, local plans for providing comprehensive medical care on a prepaid basis have been established in various parts of the country under the sponsorship of medical groups, industrial organizations, labor unions, farm cooperatives, and other local agencies. These independent plans are able to provide medical care of comprehensive scope in return for the collective per capita premium income only because the services are rendered to the insured by physicians engaged in organized group practice, who together comprise all the required professional, laboratory, X-ray, and other specialty branches of medicine and surgery. Under this system of completely prepaid group practice, financial barriers to prompt utilization of the needed medical, laboratory, and X-ray services can be eliminated and the insured families are able to enjoy all the major benefits of modern medicine, including prevention and early disease detection. In our aging population, disease prevention and early disease detection as well as medical care during chronic illness must be included in a medical-insurance program if it is to meet the needs of the public.

In this age of highly specialized professional skills and medical technology, the total medical needs of an insured population can best be met by such balanced teams of physicians, specialists, and technicians trained in the the great variety of skills and technics which today constitute modern medicine. The comprehensive-prepayment plans combine these medical skills and technics in the form of group practice and place them freely at the disposal of people of moderate means in return for the per capita income derived from insurance premiums. Each insured family has a family doctor who has been selected by the subscriber from the family physicians on the staff of a medical group. The clinical laboratory, X-ray diagnosis and therapy services, pathology, physical therapy, and visiting nurse services of the group are freely at the disposal of the family physicians as are all the consulting services of the group's specialists in the various branches of medicine and surgery without financial deterrents to their full use.

An argument commonly advanced by opponents of prepaid group practice is that it does not give subscribers free choice of any licensed physician in the community. From the standpoint of a subscriber, this has absolutely no validity, for he exercises his choice when he decides to join the plan as a member of his enrolled group of insurees and he is at liberty to drop out of the plan at any time. He is also at liberty to consult any other physician at any time that he wishes. It is certainly desirable that families of low and moderate income be given the opportunity to enjoy the benefits of comprehensive-medical care through prepaid group practice if they prefer it to so-called free choice of individual physicians and specialists whose services they cannot afford on a fee-for-service basis.

Families that receive all their medical services from a prepaid medical group can completely budget the costs of their total medical care throughout the year. If satisfied with the full scope and quality of the care provided for them by the medical group, the insured population has no need to purchase medical care from any other physician. Therein lies the cause of complaint and resistance by the opponents of prepaid group practice in every part of the country in which it has been established.

Local medical societies consist largely of solo practitioners who usually resent the economic and professional competition of

group practice and will tolerate only a fee-for-service method of solo medical practice in insurance plans. Medical societies are therefore prevented by their membership from taking any part in modernizing the organization of medical care into group practice even though it is required by the high degree of specialization characteristic of the times in which we live. Because of local resistance to progress, programs of comprehensive medical care through prepaid medical group practice have grown very slowly and have as yet reached only 4 million people.

At the national level, the American Medical Association has accepted the principle that independent groups of physicians and community leaders should be permitted to experiment with newer patterns of prepaid medical care and group practice. State and county medical societies cannot or will not initiate or operate such experiments because of their political composition. A widespread spirit of intolerance to change pervades the thinking and actions of their leaders and in some States laws have been enacted at the instigation of medical societies which actually prohibit prepaid group practice. Some local physicians are even now seeking to alter or reinterpret the Code of Professional Ethics for the purpose of obstructing the development of the only form of voluntary health insurance which has thus far been able to provide comprehensive medical care at a cost which people of low and moderate income can afford on a prepaid basis.

On July 16, 1946, an editorial in the Journal of the American Medical Association warned that such obstructive behavior by physicians may itself be unethical.[1] In spite of these pronouncements, the conflict at the local level remains unchanged and now calls for more positive action by national authorities within the profession itself or else intervention by Government in the public interest.

ORIGIN OF HIP

In 1947, after a 4-year study of the problems of medical care, the New York Academy of Medicine concluded that prepaid group practice is the logical and evolutionary development of medicine in the changing order. In 1942 and 1944, the mayor of the city of New York, the Honorable Fiorello H. LaGuardia, announced that the city would pay half the premiums of nonprofit group health insurance for municipal employees and their families if insurance coverage could be made truly comprehensive and employees and their families would be protected against additional medical bills. In order to make it possible for the city to pay half the premium cost, permissive legislation was enacted by the State legislature in 1946. Following a prolonged study of nonprofit medical insurance plans in various parts of the country, the founders of the health-insurance plan of Greater New York were convinced that medical society sponsored plans, because of the current political structure of the societies, could not change the current pattern of medical practice so as to provide the public with an opportunity to purchase comprehensive medical care. HIP was therefore established on March 1, 1947, as an independent nonprofit medical insurance plan under a board of directors composed of representative community leaders from labor, business and industry, Government, and the medical profession. It was designed to serve wage earners employed in private business and industry as well as governmental employees. The board of directors operates the plan as a community trusteeship. As in the case of voluntary hospitals, the entire responsibility for medical matters and the determination of all professional standards are delegated to a medical board and the medical aspects of the program are supervised by a medical director and his staff.

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Working capital was required during its formative period and the first year of operation. As this was the first experimental demonstration of comprehensive medical care under community-wide sponsorship, several philanthropic foundations supplied loans, which are being rapidly repaid out of premium income. From our experience it is evident that similar projects cannot be established without financial aid in the form of grants or loans either from industry, labor groups, consumer, or farm cooperatives, or, if it is to be under community sponsorship, from government. The role of government in the promotion of plans for comprerensive medical care through prepaid group practice was suggested in the 1947 Report on Medicine in the Changing Order of the New York Academy of Medicine.[2] Once established, such plans can become self-supporting, paying adequate remuneration to their physicians and repaying the initial loans.

After 7 years of operation, the health-insurance plan of Greater New York is providing comprehensive medical care to almost 400,000 insured persons. As a nonprofit agency established under the State's insurance law, it is operated in the black and has accumulated ample financial reserves as required by the State's superintendent of insurance. The services are provided by 30 medical groups, 29 of which are located in various sections of the city and 1 in an adjacent county. The medical groups are autonomous and are independent contractors. Each group includes an adequate number of family physicians proportionate to its enrollment size and a complete roster of qualified specialists representing the 12 basic specialties of medicine and surgery. They comprise altogether about 1,000 physicans, of whom about 450 are family doctors and about 550 are qualified specialists. The required professional qualifications for membership in a group are determined by an impartial medical control board of 15 representative physicians. The quality of medical care is supervised by the medical department of HIP.

Under a family-type contract, the cost for an individual subscriber without dependents is $42.72 a year, for a couple $85.44 a year, and for a family of any size $128.16 a year.[3] A family with 12 children pays no more than a family with 1 child. Allowing for large families, the average cost per individual is $36.36 a year. Employers are required to pay at least half the premium so that the weekly contribution of a single employee is $0.41, of a couple $0.82, and of a family of 3 or more, $1.23.

For providing all the care which may be needed by the insured families, HIP pays each medical group a capitation of $29.40 per annum for all persons on its rolls. After deduction of the cost of operating its medical group center and of retirement benefits, the remainder of the capitation income is available to a group for the payment of salaries of its participating physicians, most of whom are partners in the group. When a group reaches an average enrollment (14,000), the remuneration of its physicians is at least as high as the average reported incomes of other physicians and specialists in the community and the physicians enjoy added benefits of security not possible for the solo practitioner.

There are no deterring extra charges for any medical services which the insured may require in their homes,[4] in physicians' offices, medical group centers, or in hospitals. Every kind of medical and surgical service is available to them, including X-ray diagnosis and therapy, radium and radio-isotope therapy, diagnostic laboratory services, physical therapy, visiting nurse services, and even ambulance transportation without extra charge.

Footnotes at end of speech.

The plan erects no barriers by reason of age, sex, or preexisting illness, injury, physical defect, or pregnancy, either to admission to its rolls or to utilization of services thereafter. There are no waiting periods for medical care for preexisting illness or pregnancy. Reliance is placed solely upon group enrollment to protect the plan against the adverse experience to which unguarded individual enrollment would expose it.

Since the first day of operation of the plan, a division of research and statistics in HIP has recorded every medical service to every enrollee. By means of modern statistical machinery, these data can be thoroughly recorded, analyzed, and evaluated. The utilization rates of medical, surgical, and laboratory services by all age groups and especially the plan's experience with old people and with maternal and infant care will provide valuable data for future programs of medical care. An intensive study of the experience of the plan during its first 5 years is now being made by a special committee of impartial experts under the chairmanship of Dr. Lowell Reed, president of Johns Hopkins University, which is being financed jointly by the commonwealth fund and the Rockefeller Foundation. In addition to a longitudinal study of the plan's experience with its insured population, the special research project conducted by Dr. Reed's committee has included an investigation of the sickness and medical-care experience of large and representative samples of households in New York City and in the HIP population, totaling more than 25,000 persons. The publications emanating from the research division are available to you as well as all of the plan's recorded experience.

HIP also maintains a division of preventive medicine and health education as one of its important activities. It is the responsibility of the expert staff of this division to promote adequate utilization of medical services by the insured population, especially preventive services and those concerned with early disease detection. The objective is to have every family select a family doctor and use him and the specialists and laboratories of their medical group for the prevention and the early detection and treatment of illness. The effect of this wide exposure of the insured population to medical care can be measured by the fact that at least 74 percent of the enrolled members of the insured families are now using their physicians' services within a year and this rate is rising as our health education program takes hold. The average rate of utilization of physicians' services by the entire insured population is 5.3 services per year per person. The lack of financial barriers to complete medical care has not led to any significant amount of needless use of the services by the insured. Subscriber abuse is minimal and easily corrected.

The experience of HIP and of many similar plans throughout the country is now sufficiently voluminous to demonstrate that comprehensive medical care through prepaid group practice is professionally feasible and financially practical from the standpoint of both the doctors and the public. There can also be no question of the importance of prepaid comprehensive medical care to public health.

To facilitate its growth, two things are necessary: (1) Elimination of interference by local professional societies with prepaid group practice; (2) financial assistance by Government through loans to encourage the wider extension of prepaid comprehensive medical care throughout the country under local community sponsorship.

Government at all levels may also help through the purchase of prepaid medical care for its own employees and wards. It should follow the accepted practice of purchasing medical care under group contract from the prepayment organization which

produces the best values for the price charged.

ROLE OF FEDERAL GOVERNMENT

The role which the Federal Government should take in promoting and extending adequate medical care to the insurable population of the country might well follow that which it has already taken to promote and extend adequate hospital care under the Hill-Burton Hospital Survey and Construction Act. Federal assistance to the States might first be limited to grants-in-aid to encourage the States to survey existing deficiencies in medical care within the State and to determine:

1. The extent to which the insurable population is not covered by prepayment for medical and for hospital care.
2. The gaps in benefit provisions under existing prepayment programs.
3. The means whereby the gaps in population coverage and the gaps in benefit provisions under existing programs may be eliminated.
4. The availability of voluntary insurance plans which provide comprehensive benefits for medical care in the homes, in doctors' offices, in diagnostic laboratories and X-ray services, as well as in hospitals.
5. The desire of the public for prepayment plans which will provide comprehensive medical services.
6. The existence of State laws which prohibit or make it impossible for physicians to provide such comprehensive medical care through prepaid group practice of medicine.

The State surveys should also include:

1. A determination of the nonwage and low-income group in the population which cannot afford to prepay their medical care through the purchase of voluntary health insurance.
2. The possibilities of experimentation by State and local governments with coverage of some or all of this group by voluntary medical-insurance plans.
3. The degree to which Federal assistance might be required to enable State and local governments to provide medical and hospital care to persons in the nonwage and low-income groups (the medically indigent) through prepayment.
4. The possibilities of experimentation by State unemployment funds or other State agencies with the provision of medical care for temporarily unemployed persons and their dependents through continuing the prepayment of premiums for the unemployed for care which may be needed during periods of temporary unemployment.

Small Federal grants could be employed most effectively to assist States in carrying out experimental programs designed to extend prepayment plans and comprehensive coverage under these plans to the part of the population within the State which is at present not covered or inadequately covered under such plans. In recognition of the fact that comprehensive medical service coverage under any voluntary prepayment plan requires economies and increased efficiency in operation which can be achieved only by organization of medical services as group practice, Federal aid to State and local communities is needed to encourage the establishment of prepaid group practice of medicine under local community sponsorship.

The organization of medical practice along such modern and more efficient lines requires loans to medical groups for the construction of the required physical facilities, to be repaid by them out of future earnings. Such loans for the purpose of encouraging local prepayment programs for comprehensive medical care should be limited to the acquisition of medical group centers, the purchase of X-ray, laboratory, and other professional equipment required for group practice, and the administrative expenses of the medical group center during the first year of its operation. The annual appropriations for this purpose need not be large nor would they be needed for more than 5 or 10 years, for as the loans are repaid they may be used as a revolving fund.

It can be predicted that rapid progress in the extension of prepaid comprehensive medical care will not be made until (1) such loans are made available, (2) hampering State laws are repealed wherever they exist, and (3) effective steps are taken by higher professional authorities to eliminate interference by members of the local medical profession in restraint of change from the present costly and disorganized methods of medical practice to a more modern and more economical pattern.

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[1] "Instances have occurred in which physicians, for political, commercial, or emotional reasons, have endeavored to utilize the principles of medical ethics as a means of producing embarrassment, distress, or loss of reputation of other physicians whom they envy or whose open competition they fear. The principles of medical ethics were not designed for any such purpose, and the attempt to utilize the principles of ethics for such purposes may well be in itself unethical." Editorial, JAMA July 16, 1949 (vol. 140, No. 11), p. 960.

[2] "The committee recommends that comprehensive medical services be extended by the use of voluntary, nonprofit insurance, using group practice units wherever feasible, and Government subsidy wherever necessary." Medicine in the Changing Order, Commonwealth Fund, 1947, p. 56.

[3] Subscribers to the health insurance plan must also have Blue Cross or other hospital insurance.

[4] Except a permissible $2 charge for night calls requested and made between 10 p. m. and 7 a. m.